



## **Professional protectionism; a barrier to employing a sonographer graduate?**

SEVENS, Trudy and REEVES, Pauline

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# Professional protectionism; a barrier to employing a sonographer graduate?

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## Abstract

**Introduction:** The national sonographer workforce deficit is not a new challenge and has been driven by the increasing demand for ultrasound services. The current educational models only facilitate small trainee numbers and are unable to keep abreast of the demand for trained sonographers. This is partially due to the intensive (and often one to one) sonographer training which has instigated much debate relating to alternative models of education. Alongside this, debate continues on the educational level of any future training models; one suggestion being the introduction of a graduate sonographer and the subsequent integration into the current workforce. The aim of this research was to gain a deeper understanding of the perceptions of key stakeholders in relation to potential challenges and barriers, especially associated with protectionism, and to offer recommendations to overcome these.

**Methods:** A total of thirteen semi-structured interviews were conducted and the data analysed using a constructivist Grounded Theory approach.

**Results:** The findings suggested that sonographers, as an occupational group, presented challenges and resistance to change as a mechanism for protecting their own roles. This research highlighted that responses to the concept of integrating a new sonographer graduate into the workforce were deeply rooted and centred around power and dominance.

**Conclusion:** The findings from the research identified that tradition and professional culture created barriers for the future development of the sonography profession and that there was an urgent need for change which, it was proposed, could be achieved through clear leadership to manage and implement the changes.

## Keywords

- Sonography graduate
- Sonographer
- Professional dominance
- Leadership
- Professional identity
- Professional boundaries

## **Introduction**

The latest figures from the Centre for Workforce Intelligence <sup>1</sup> reveal a national (United Kingdom) sonography workforce deficit of 10% with a high proportion of the current workforce within 5-15 years of retirement age <sup>1, 2</sup>. This is not a new challenge as national deficits were being reported in 2012 as being at 18% <sup>3</sup> with heavy reliance on agency staff to cover demand in many ultrasound departments. The situation is compounded by current training models only being able to accommodate small numbers of trainees due to the intensive one to one training and lack of placement opportunities. The increasing demand for ultrasound services and expansion of clinical applications for ultrasound continues to rely greatly on radiographers undertaking postgraduate study in ultrasound <sup>1, 4, 5</sup> and subsequently being employed at advanced practitioner level. This has created a workforce where all are banded at grade 7 and above with very few examples of sonographers being employed at lower bands. There is a lack of a defined and clear career structure or pathway.

Alternative training routes have started to be piloted with a small number of Higher Education Institutes in England introducing direct entry for ultrasound both at undergraduate and postgraduate levels. More recent developments have seen the formation of a sonographer degree apprenticeship trailblazer group and subsequent development of the degree apprenticeship standard for sonography. However, there is still a lack of national consensus for the future of ultrasound education.

Concerns over regulation are also entrenched within the workforce crisis as the title 'sonographer' is not a protected title and there is reliance on sonographers to maintain their registration in their first professional area, for example, radiographers with the Health and Care Professions Council (HCPC) <sup>6, 7, 8, 9</sup>. This can affect employment opportunities as discrepancies exist between hospital trusts (and even within the same trusts) as to whether HCPC registration (or equivalent) is essential for employment. Furthermore, it can subsequently create professional identity ambiguity for occupational groups that are registered and regulated under one professional title and employed as another.

There is a distinct notion of protectionism from the current workforce around aspects of banding and pay, for example, creating challenges to the introduction of a lower band sonographer <sup>10, 11, 12</sup>. It was hoped this research would therefore, provide valuable insight into key stakeholder views and potential recommendations to allow a seamless introduction and integration of a new model of education for sonography.

## **Method**

### **Methodology**

Ethical approval for the study was gained from the University Research Ethics board (reference 1501061 4010) and relevant research and innovation departments with

the NHS hospitals. Ethical considerations were paramount throughout the research process. The initial research question was

'What are the perceived benefits and challenges of employing a new sonographer graduate from the perspective of key stakeholders?'

which was used to guide the literature review and data collection. In the context of this study, the term 'graduate' related to direct entry into sonography and undertaking a Bachelor of Science degree. There was very little research or guidance found relating to the new sonographer graduate and how they would be integrated into the current workforce and career structure. To explore this complex clinical situation, a constructivist Grounded Theory methodology was used which is considered to be particularly useful where there are complex relationships and clinical situations. It aims to uncover new or poorly understood values and generates new theory from these <sup>13, 14</sup>.

### **Participants and sampling**

An initial pilot study was conducted with participants from a sonographer background and radiology services manager background to allow refinement of the interview schedule. Transcribing, coding and analysis of the pilot interviews took place with checking by a second person. Following this, twelve face to face interviews, 1 telephone follow up interview and 1 telephone full interview were conducted by the researcher to gain rich and detailed data. The preferred method was face to face and the two telephone interviews were as a result of geographical issues.

Participants included 4 ultrasound managers, 5 radiology services managers, 2 consultant sonographers and 2 'other relevant stakeholders' (term used to preserve anonymity). Inclusion criteria for participants related to having in depth knowledge or experience of the ultrasound workforce and employability. Theoretical sampling ensured the inclusion of the most appropriate participants <sup>15</sup> and to guarantee a range of different experiences, backgrounds and roles, ensuring a diverse sample with a range of perspectives. The ultrasound managers all had a sonography background with varying years in post, as had the consultant sonographers. The radiology services managers were from a range of backgrounds and years in post.

Initial contact was made via email to invite participants to be involved, with follow up email correspondence including the participant information sheet and consent form to ensure informed consent was gained. The interviews were recorded using a digital Dictaphone and transcribed verbatim. A staged approach was implemented for data collection which ran from August 2015 to August 2016 allowing data collection and analysis to be undertaken concurrently, with emerging ideas and theories guiding subsequent interview questions and focus. No participants approached declined to be involved and data collection continued until saturation had been reached (no new data emerged), strengthening emerging theories <sup>15</sup>.

## Data Analysis

Following transcription, complete open coding method was used initially to identify anything and everything of interest from the transcripts using NVivo version 10. They were coded with a word or brief phrase that captured the essence of interest and all relevant codes assigned to each point of interest<sup>16, 17, 18, 19</sup>. Memo writing (described as the intermediate stage between data coding and theoretical analysis<sup>18</sup>) was also implemented at the early stages of data analysis in keeping with Grounded Theory methodology. Memo writing was conducted concurrently to allow ideas and theory building to occur<sup>19</sup> through the collection of ideas, thoughts and challenges<sup>18, 20, 21, 22</sup>. This also provided an audit trail<sup>23</sup> increasing the rigour and credibility of the research and emergent theory<sup>20, 24</sup>. The process also allowed any gaps to be identified which were explored in later data collection<sup>17</sup>. Initial codes and associated categories were checked by a second person to ensure these were unbiased.

Focussed coding was then utilised to develop tentative categories and theory testing as the research progressed.

## Results and discussion

Anonymised participant's quotes are included in the categories supported by theoretical and relevant published literature.

### Resisting change

When asked about the potential for introduction of a graduate sonographer at band 5/6, many participants spoke about the existing workforce being comfortable with the current structure and being resistant to change.

*'so obviously established people who are quite comfortable with the current career structure will have something to say about it' (P4)*

*'I just think there is a resistance to looking at it' (P7)*

There was a distinct trait of 'why should we do things differently?', particularly in relation to training routes and educational level studied.

*'I did three years to get radiographer trained and then I've worked all this time to be a sonographer and got to a band 7 and now they're coming in at a band 5 and they don't have to do all that, why is that fair?' (P13)*

There seemed reluctance to explore other options which were not embedded into the professional culture and developed through socialisation and participation in the role associated with the occupational group<sup>25, 26, 27</sup>. This can be detrimental to professional growth<sup>27</sup> as these learnt behaviours are then passed on to new members of staff with further resistance to change.

*'I think certain people don't like change, they're trying to protect their own role and I think it probably was the same with radiographers and assistant practitioners' (P1)*

*'well, I mean there's always some resistance to change and people are very wedded to their professional identity' (P4)*

Reactions to change can be unpredictable and lead to dysfunctional consequences as they often promote feelings of loss and stress <sup>28, 29</sup> as demonstrated in some participants' responses.

*'It can sometimes feel like (pause) you're going to have things taken off you perhaps or what am I going to lose?' (P13)*

Participants highlighted the complexities associated with there being a diverse range of stakeholders (cultural diversity) including a number of occupational groups utilising ultrasound as part of their role that could potentially be affected by the change. In addition, the associated professional or regulatory bodies of these occupational groups also need to be consulted as they often have requirements which could present competing demands <sup>28, 30</sup>.

*'HEE [Health Education England] are just discovering just how complex this really is where the tentacles go and just how difficult it is to cut away through er it's incredibly complex' (P7)*

*'I suppose also the fact that it's not just one profession that delivers sonography we're coming at it from all different professions....we'd all be coming at it from a different view so I think that's, it's complex' (P6)*

This diverse group of contributors can create challenges in ensuring the implementation plan for change is as uncomplicated as possible to facilitate transparency and ownership. To try and facilitate this clear communication strategies are paramount. Participants stressed the importance of communication and consultation in implementing change and keeping all concerned informed. All agreed the key to success was involving the existing workforce and ensuring the value of the change was understood and accepted.

*'I think the biggest thing is, new systems are only successful if everybody that's involved is on board and has a vested interest' (P11)*

### **Being in control**

Despite this resistance to change, radiographers (including sonographers) have challenged traditional boundaries in order to advance their own roles which has been recognised both by the professional body and national policy<sup>9</sup>. Participants raised difficulties faced with achieving this.

*'it's the professional boundaries that prevent that' (P6)*

*'in terms of more higher areas then more consultant sonographers so why hasn't that happened? I think that's mainly down to lack of funding and in some instances the erm the consultant radiologists not supporting it and not wanting to let go' (P6)*

*'I think in some erm trusts erm that's a very big problem, here we're managing to break down those barriers slowly but I do feel in some trusts, especially the older radiologists, you know, who don't want to let go' (P6)*

The participants recognised that radiologists were being protectionist of their own roles and striving to maintain the professional boundaries by being reluctant to delegate roles to sonographers. This variation in support from radiologists for radiographers to achieve consultant roles has previously been identified<sup>31, 32</sup> and was clearly evident in a recent report<sup>33</sup>,

'The tragedy of the latest statement is that out of 1158 words, 404 are spent not in making the case for better patient services but instead in denigrating and undervaluing the capabilities of advanced practitioner radiographers'<sup>32</sup>.

It is evident that barriers still exist centred around the perceived lack of medical knowledge on the part of non medically trained health professionals<sup>32 34 35 36</sup> as radiologists strive to be in control.

Participants believed this subservient relationship still exists with potential to hinder progression for radiographers and sonographers claiming, the situation was 'unique in radiology', making them different from other AHP groups<sup>37</sup>.

Participants spoke of the territorial conflict between sonographers (and radiographers) and radiologists, trying to keep control and protect their own areas of practice as they feel threatened<sup>38</sup>.

*'it's that old thing isn't it radiologists do feel threatened' (P9)*

*'I still think the radiologists are trying to keep, keep control' (P11)*

Comparisons can be drawn to the current sonographer workforce being reluctant to delegate roles to a lower band sonographer amidst concerns of watering or dumbing down the current sonographer role<sup>11, 39</sup>.

Participants highlighted that

*'obviously sonographers aren't going to want to be down banded are they?' (P4)*

*'we're very, very er in danger of, severely in danger of dulling down everything' (P5)*

*'I think they feel it's a weakness or a step down to have sonographers at lower grades' (P9)*

This desire to be in control through gatekeeping and protection of one's own role as described above, maintains professional demarcations between occupational groups and allows the exertion of power and control over entry to the group (sonography). The group functioning to strengthen professional boundaries through categorisation can be explained using Social Identity Theory<sup>40</sup>. Team functioning is improved when there are common goals<sup>41</sup> (protecting their own role) and the team members must co-ordinate and work together to maintain these shared goals<sup>42</sup> (gatekeeping). Team members become 'in-group' members<sup>43, 44</sup> holding similar attributes.

One similar attribute of the in-group members is statutory registration and some employers were perceived to be gatekeeping by stipulating registration with a regulatory body as a requirement for employment of sonographers. However, participants highlighted discrepancies, not only between hospital trusts, but also within the same hospital trust. On further exploration, participants were unable to offer any real alternatives to protection of public safety with a perception that the voluntary register was not a suitable alternative.

The majority of the current sonography workforce remain registered in their first professional area, most commonly as radiographers with the HCPC<sup>1</sup>. This creates ambiguity for the professional identity of sonographers as they are registered as a different professional than that of their main role<sup>45</sup>.

This perception that sonographers must first have undertaken a professional qualification in another area, such as radiography, can be compared to the historical development of midwifery as a distinct profession rather than what has been termed a sub discipline of nursing<sup>46</sup>.

Stevens<sup>47</sup> highlighted the heated debate which preceded this split in the late 1980's with two distinct sides. Opinions ranged from being adamant that a midwife without any nursing background would not be safe to practise whereas the opposing opinion was that midwives should be autonomous. Participants raised concerns over direct entry sonographers having no background in imaging, health care or previous patient contact. These concerns are echoed in a recent Australian study<sup>48</sup> exploring the barriers to employing midwifery graduates into areas traditionally only the remit of experienced midwives. This study demonstrated how professional culture was a challenge, not a barrier and strong leadership was required to facilitate change.

### **Leadership and power**

Despite the reported desire of the current workforce to maintain their professional status and power, participants perceived sonographers lacked professional identity (associated with status, power and prestige).

*'we haven't really got a professional identity, is what I feel' (P6)*



There was a reported lack of recognition for radiographers and sonographers from both health professionals and the public which can take many years to overcome <sup>49</sup>.

Many participants felt the role was poorly understood by service users, carers and other professionals

*'the public don't know what a sonographer is, they don't know what a radiographer is' (P6)*

*'it's still considered from an outside view doctors and nurses' (P13)*

Participants spoke of how sonographers were perceived to hold greater power, compared to other health professionals, especially in terms of negotiating higher pay <sup>50</sup>. There was a distinct notion that sonographers had a louder voice and more influence and there were many references to sonographers being special

*'it's quite nice to be special and needed' (P4)*

*'they've made us too special, all of us' (P5)*

This feeling of being special may endow perceived influence during the current workforce shortage, but this does not necessarily translate to real power in terms of leadership and positional dominance. The perception of holding power is, arguably, transient as it will undoubtedly diminish as the workforce deficits are reduced <sup>45</sup>.

Participants reported a distinct lack of sonographer representation and constitutional members at national level creating difficulties for development of sonography as a profession. This is despite the majority of sonographers being employed at the equivalent of advanced practitioner level or above with only two sonographers nationally achieving the SCoR accreditation for advanced practice <sup>51</sup>. In addition, despite leadership being identified as one of the core values of advanced (and Consultant) practice <sup>52, 53, 54, 55, 56</sup> only half of the respondents in a recent study <sup>57</sup> perceived this to be integral to their role.

In addition, many of the participants in this study alluded to the notion that it was someone else's responsibility to take the sonography profession forward. This could be perceived as laissez-faire leadership (or the non-leadership factor <sup>58, 59, 60</sup>).. Responsibility is abdicated and decisions delayed with a detrimental effect on team effectiveness and decision making <sup>61, 62, 63</sup>.

This study suggested that leadership in sonography was weak and participants advocated delegation of decision making to someone else by calling for a national drive from a professional body, for example. At the time of writing there was still no agreement as to the way forward for sonography education, training and employment resulting in different models being implemented by different Higher Education Institutes.

## **Limitations of the study**

It is acknowledged that the sample for this study could be perceived as relatively small which is typical of an interpretative Grounded Theory study<sup>64, 65</sup>. There is also a degree of reliance on the researcher to identify and select an unbiased heterogenous sample and to attempt to minimise their own perspective through theoretical sensitivity and reflexivity throughout the study<sup>17</sup>. Authors claim the benefits of theoretical sampling outweigh these limitations<sup>66, 67</sup>.

The recommendations made require further exploration and research to establish a robust future for sonography.

## **Conclusion**

As the research developed and theory emerged, it became evident that the potential challenges of introducing a new educational model, and integration of the subsequent graduates into the department, were more deeply rooted than had been perceived at the outset. It can be argued that these views are entrenched within the occupational group through tradition and professional culture which needs to be challenged through strong leadership and education. This research highlighted that, whilst sonography had small local pockets of excellent leadership (one of the core domains for advanced and consultant practice), there was a distinct lack on a national level. This also extended to the disappointingly small number of sonographers achieving accreditation for advanced practice and evidencing their practice to the four established domains. An increase in the number of sonographers holding both accreditation and a full Masters level (or higher) qualification could indicate that sonographers are further embracing and building upon both research and leadership in striving for professional identity.

The research also calls for effective and strong national leadership; essential to manage and implement change by sonographers taking ownership of these changes. This would minimise any untoward and unwanted consequences and allow the aspirations for sonography to be achieved as a profession.

There is a need to promote sonography and increase recognition by both the public and colleagues. It is acknowledged that this is difficult to do without strong leadership to manage and implement change which this study suggested requires development to move sonography forward towards professionalisation.

3431 words including the key words and abstract

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